

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

12679

State File No. \_\_\_\_\_

Registration District No. 18

Primary Registration District No. 6139

Registrar's No. 3

1. PLACE OF DEATH:

(a) County Texas

(b) City or town Rural Morris  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Texas

(c) City or town Rural  
(If outside city or town limits, write "RURAL")

(d) Street No. Near Dykes  
(If rural, give location)

(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME William M. Clark 462

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 5  
year 1940 hour 11 minute \_\_\_\_\_ A.M.

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: Feb. 12 1870  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Mar. 2  
1940 to Mar. 5th 1940  
that I last saw him alive on Mar. 5th 1940  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

61 0 23 hr. \_\_\_\_\_ min \_\_\_\_\_

Immediate cause of death Chronic Pneumonia Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

9. Birthplace \_\_\_\_\_ Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

Other conditions Chronic nephritis  
(Include pregnancy within 3 months of death)

11. Industry or business \_\_\_\_\_

12. Name William Clark

13. Birthplace \_\_\_\_\_ Mo  
(City, town, or county) (State or foreign country)

14. Maiden name Henry Henes

15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant's own signature Mrs May Jones

(b) Address St. Grove, Mo.

17. (a) Burial (b) Date thereof Mar. 7 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Dykes

18. (a) Signature of funeral director Hayford V. Elliott

(b) Address Houston Mo.

19. (a) Mar 12 1940 (b) Paul E. McCall  
(Date received local registrar) (Registrar's Signature)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

(Specify type of place) \_\_\_\_\_  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

28. Signature J. B. Herron (M. D. or other) \_\_\_\_\_  
Address Houston, Mo Date signed Mar 6

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No. ....

working under my personal supervision.

**RECEIVED**  
District Health Officer No. 5,

District File Number 440 414

Date Filed 4/11/40

Signed Frank E. Hood

Licensed Embalmer No. 4026

P. O. Address Houston, Mo.

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**